# 3 Pharmacy Guidelines Contents

# 3.1 Pharmacy Service Policy

## 3.1.1 Introduction

This section covers Medicaid services provided by pharmacies as deemed appropriate by Medicaid. It addresses the following:

- Pharmacy requirements
- Participant services
- Drug coverage
- Prior authorization
- Medical supply items
- Payment
- Claims submission

## 3.1.2 Overview

Medicaid reimburses licensed pharmacies for covered drugs provided to Medicaid participants. Medicaid pays for most prescription drugs when ordered by a licensed practitioner. See ***Section 3.3.4, Drugs Excluded by Medicaid***, for a list of drugs excluded from coverage. If uncertain about drug coverage or billing units, call the Medicaid Automated Voice Information Service (MAVIS). To access MAVIS, call 383-4310 from the Boise calling area or (800) 685-3757 outside the Boise calling area.

## 3.1.3 Pharmacy Requirements

### *3.1.3.1 In-state Requirements*

Payment for covered drugs can only be made to a "drug outlet" as defined by Idaho Code (Title 54, Chapter 17) and properly licensed by the Idaho Board of Pharmacy. In addition, a licensed pharmacy must apply for and receive a provider number from the Idaho Medicaid Program.

Each business location must obtain and bill with a separate provider number specifically assigned to that pharmacy location. When there is a change of ownership, a new provider application must be submitted for assignment of a new provider number along with a request to inactivate the old provider number.

For more information on provider enrollment, see Section 1.2.2.

### *3.1.3.2 Out-of-state Requirements*

Licensed pharmacies outside of Idaho can also be paid for prescriptions dispensed to Idaho Medicaid participants if they have applied for and received a Medicaid provider number from Idaho. Out-of-state pharmacies shipping or mailing prescriptions into Idaho must be licensed by the Idaho Board of Pharmacy.

### *3.1.3.3 Unit-Dose Providers*

Medicaid pays only for those unit-dose products utilized by the participant. For Medicaid Title XIX payment purposes, unit-dose dispensing is defined as a system of providing individually sealed and appropriately labeled unit dose medication that ensures no more than a 24-hour supply in any participant's drug tray at any given time.

Delivery of drug cabinets containing each day's medication is to be at a minimum of five days per week. These systems would normally be utilized in

hospitals and skilled nursing facilities. The blister pack systems commonly used in skilled nursing facilities, shelter homes, and residential care facilities are **not** considered unit-dose systems as outlined above.

Pharmacy providers, who, according to Medicaid regulations, are eligible for unit-dose dispensing fees, have several additional options when submitting the National Drug Code (NDC) number for billing purposes.

- Use the NDC code when dispensing manufacturers' prepackaged unit-dose medications.
- Submit claims for unit-dosed oral solid medication packaged by the pharmacy (extemporaneously packaged unit doses) using the NDC on the container from which the dose was packaged. The dispensing fee includes consideration for this packaging service.
- Bill only for the number of whole tablets used to prepare the doses when billing for half and quarter tablets.
- Unused unit-dose medications, vials, ampules and blister-packed medications shall be returned to the dispensing pharmacy as authorized by the Idaho Board of Pharmacy and credited to Medicaid.

**Note:** Unit Dose services are not covered for **CHIP-B** participants.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

### *3.1.3.4 Payment to Dispensing Provider*

The pharmacy provider who provided the service must bill pharmacy-based services. Federal regulations (42CFR447.10) require Medicaid to pay the provider that actually provides goods or services. Payments cannot be made to "Pharmacy A" for prescriptions dispensed by "Pharmacy B."

### *3.1.3.5 Participant Has Other Insurance*

The Idaho Medicaid program requires that, for participants with other pharmacy insurance coverage, drug claims must be billed to the participant's other insurance(s) prior to submission to Idaho Medicaid for payment. This policy does not require the Medicaid participant to pay towards their prescriptions.

When an insurance company requires the participant to pay the full prescription price first, Medicaid will provide payment to the pharmacy and will then coordinate benefits with the other insurance. No money should be collected from the participant for a covered service. Pharmacies are requested to bill as follows:

**Electronic (POS) or Batch claims**
Bill Medicaid but do not enter a payment for other insurance. Submit claim with the other coverage code 04 (Other coverage exists - payment not collected).

When an insurance company requires a co-payment or partial payment from the Medicaid participant, do not collect the partial payment or co-payment from the participant. Follow billing instructions for billing Medicaid as a secondary insurance.

Except as listed above, if denial code **41** (Submit bill to other processor or primary payer) appears, drug claims must be billed to the participant's other insurance(s) prior to submission to Idaho Medicaid for payment. In order to submit an electronic point of service (POS) claim for a participant with other insurance, the following information is required:

- Other Coverage code:
  - **0** Not Specified
  - **1** No other coverage identified

**2** Other coverage exists-payment collected (use this value if partial payment was made by other insurance).

**3** Other coverage exists-partial payment

**4** Other coverage exists-payment not collected

**5** Managed care plan denial

**6** Other coverage denied-not a participating provider

**7** Other coverage exists-not in effect at the time of service

**8** Claim is a billing for co pay

- Carrier code: The National Electronic Insurance Clearinghouse (NEIC) code identifying the Other Insurance Carrier. Use a valid code for the participant's other carrier. Carrier code is typically listed on a participant's insurance card. The list of carrier codes in the PES software is not a comprehensive list. There may be other NEIC numbers accepted and used.
- Coverage Type

  **01** Primary

  **02** Secondary

  **03** Tertiary
- Amount paid by other insurance (include dollars and cents)
- Other insurance paid date (MM/DD/CCYY)
- Other insurance reject code (indicating the reason the other insurance denied payment (if applicable) **Do not use a reject code if the other insurance made a partial payment.**

  **60** Product/service not covered for patient age

  **61** Product/service not covered for patient gender

  **65** Patient is not covered

  **67** Filled before coverage effective

  **68** Filled after coverage expired

  **69** Filled after coverage terminated

  **70** Product/service not covered

  **76** Plan limitation exceeded

  **78** Cost exceeds maximum

  **AG** Days supply limitations for product/service

  **M1** Patient not covered in this aid category

  **M2** Recipient locked in

  **M4** Prescription/service reference number/time limit exceeded

  **PA** PA exhausted/not renewable

  **P5** Coupon expired

  **RN** Plan limit exceeded on intended partial till values

### 3.1.4 Prescription Records

Prescriptions must be dispensed according to *Federal Rules and Regulations; Idaho Code (Title 54, Chapter 17,* and *Title 37, Chapter 1, 27, and 32)*; and the Idaho State Board of Pharmacy Rules, IDAPA 27.01.01,

and the *Rules Governing the Medical Assistance Program (IDAPA 16.03.09.805-818)*.

Providers must maintain records of prescriptions and all other records necessary to document services rendered and ordered by a licensed practitioner. Paper records must be on file and readily available for utilization review by DHW for a minimum of 5 years after the date of service. This includes a legal prescription on file that contains at a minimum:

- name of the participant
- date of the prescription (MMDDYY)
- name and strength of medication prescribed
- amount to be dispensed
- name of prescriber
- number of refills allowed unless it is zero
- prescription file number (either handwritten or pre-printed label)

Additional records include, but are not limited to:

- invoices showing product (with labeler) purchased by the pharmacy
- claim copies
- remittance advices
- participant profiles or a daily record for filled and refilled RXs

Refills on all legend drugs must be authorized by the prescriber on the original or new prescription order on file and each refill shall be recorded on the prescription or, logbook, or computer printout or on the participant's Medicaid profile.

Payment is denied for prescriptions not dispensed in accordance with the above rules and laws.

### 3.1.5 Prescriber License Number

Idaho Medicaid requires pharmacy providers to report the prescriber's valid state license number. This requirement applies to electronic, batch, and paper pharmacy claims. Claims with invalid prescriber license numbers will be denied payment.

During normal business hours, if a pharmacy receives a prescription written by a prescriber for which the pharmacy does not have the license number, the pharmacy should obtain the license number from the prescriber or from the Medicaid Pharmacy Website, and submit the pharmacy claim with the valid license number. If the claim is rejected for invalid prescriber license number, the pharmacy should contact EDS.

If the pharmacy claim is being submitted after normal business hours or on the weekend, the pharmacy may input the current date (MMDDYY format) in the prescriber number field of electronic, batch, and paper claims.

Pharmacies that submit claims using the DATE rather than the prescriber license number are required to rebill with the correct license number within three business days.

Pharmacies may request a prescriber be added to the Medicaid records for future prescriptions by calling EDS, Monday through Friday, 8:00 a.m. to 5:00 p.m., MT at (800) 685-3757 or (208) 383-4310 (Boise calling area) or by faxing the information to (208) 395-2198. Providers will need to include the prescriber's complete name, address, phone number, and license number.

The electronic version of the prescriber list is available on the Medicaid Pharmacy Website. To obtain a current listing of prescribers and their corresponding state license number, refer to the Idaho Medicaid website at www.healthandwelfare.idaho.gov linking to the Pharmacy Program.

Pharmacies may request a hard copy of the Medicaid prescriber license list by contacting EDS provider services at (800) 685-3757 or (208) 383-4310 (Boise calling area). Ask for “Provider Enrollment”. There is a $10.00 handling fee for hard copy lists.

# 3.2 Participant Services

## 3.2.1 PW Program Coverage

For women eligible for Medicaid under the Pregnant Women (PW) Program and during the presumptive eligibility (PE) period, **pregnancy related medications** covered under the Medicaid Drug Program are reimbursed according to current policy. The participant is usually eligible for 60 days postpartum coverage. Medical necessity forms are not required for drug claim processing.

## 3.2.2 EPSDT Program Coverage

Certain services, including drugs, not covered under normal program coverage may be prior authorized for participants less than 21 years of age through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Prior to servicing, send a copy of the prescription, along with a statement of medical necessity, diagnosis, and duration of treatment, to:

Idaho Medicaid
Bureau of Medical Care
EPSDT Coordinator
P.O. Box 83720
Boise, ID 83720-0036

FAX (208) 364-1864

## 3.2.3 Foster Children

Providers can verify eligibility for foster children enrolled in the Idaho Medicaid program. Bills for legend or non-legend drugs not included in the scope of the Medicaid drug program should be sent to the appropriate regional foster care office.

## 3.2.4 Long Term Care

Medicaid covers drugs included in the regular scope of coverage for all Medicaid-eligible participants in long term care facilities. This coverage does not include non-legend medication (except insulin, Permethrin rinse or shampoo, oral iron salts) or medical supply items. These products (such as syringes and needles) are **included** in routine services that nursing homes must provide for Medicaid participants, according to the Idaho Medicaid Provider Handbook for long term care facilities. Only nursing facilities or intermediate care facilities for the mentally retarded (ICF/MR) must provide these products as part of routine services.

## 3.2.5 Hospice Medications

Hospice providers contract for all services including medications that pertain to the particular terminal disease state. All other prescriptions not related to the terminal state are to be billed to Medicaid on a paper Pharmacy Claim form. Document both the hospice diagnosis (obtain from the hospice provider) and the other diagnosis for which the drug is prescribed in field 21 of the paper claim form or on an attachment.

## 3.2.6 Lock-In

Certain Medicaid participants are “locked in” to a specific physician and/or pharmacy. For these Medicaid participants, Medicaid pays only for services ordered or rendered by the providers specified as the participant’s lock-in provider(s). A participant’s lock-in provider(s) can be identified using MAVIS. If a participant has been referred to another provider by the lock-in provider, note this on the claim and include the name of the lock-in provider.

Documented emergency services rendered in the emergency department are exempt from the lock-in requirements. Prescription drugs are not exempt regardless of the emergent status.

### 3.2.7 County Welfare Assistance

If the participant does not have sufficient funds or declines to accept responsibility for the payment of drugs in the above cases, referral to the county medical indigents program or pharmaceutical manufacturers' assistance programs may be appropriate.

### 3.2.8 Retrospective Eligibility Determination

Pharmacies are not obligated to bill for services provided on dates prior to DHW determining eligibility when the determination is retroactive and eligibility for services is back-dated, unless requested by county indigent programs.

If the pharmacy chooses to bill Medicaid for prescriptions previously purchased by the participant, the Medicaid payment must be accepted as payment in full and the entire original purchase price refunded to the participant.

There may be circumstances when the pharmacy will not be able to recover the full cost of prescription dispensing, based on Medicaid policy (such as upper payment limit drugs or the brand name prior authorization program). The pharmacy should bill Medicaid only if they are willing to accept the lower reimbursement as payment in full.

### 3.2.9 Medicaid Exception for Inmates

An inmate of an ineligible public institution can receive Medicaid while an inpatient in a medical institution. The inmate must meet all Medicaid eligibility requirements. Medicaid coverage begins the day the inmate is admitted and ends the day of discharge from the medical institution.

- A person is an inmate when serving time for a criminal offense or confined involuntarily in State or Federal prisons, jails, detention facilities, or other penal facilities.
- An inmate is an inpatient when he/she is admitted to a hospital, nursing facilities, ICF/MR, or if under age twenty-one (21), is admitted to a psychiatric facility.
- An inmate is not an inpatient when receiving care on the premises of a correctional institution.

For additional information about Prescription Assistance Programs visit

**www.RxIdaho.org**

or call

(888) 477-2669

# 3.3 Drug Coverage

## 3.3.1 Covered Services

### *3.3.1.1 Multi-Source Drugs*

Pharmacies should dispense the generic form of a drug whenever possible. Prior authorization (PA) is required for most brand name drugs when an acceptable generic equivalent is available. PA is based on medical need such as adverse reactions (clinically demonstrated, observed, and documented) that have occurred when the generic drug has been used. For information regarding the PA procedure see ***Section 3.4, Prior Authorization***.

See the Internet at: **www.medicaidpharmacy.idaho.gov**.

Listing of:
Brand Name Drugs Requiring Prior Authorization

Listing of:
Upper Limit of Payment for Multi-Source Drugs

### *3.3.1.2 Injectable Drugs*

Most injectable drugs can be billed electronically with documentation of the corresponding NDC. A limited number of these drugs such as growth hormones, hemophilia products, gamma globulins, interferons, etc., may still require paper billing because of confusing package sizes or cost. If the provider is uncertain as to the billing unit (each, ml, gm), call MAVIS at (208) 383-4310 or (800) 685-3757.

### *3.3.1.3 Immunization Programs*

**Provider Purchased Vaccines**
Vaccines purchased by the pharmacy should be billed electronically or on a paper Pharmacy Claim form with the appropriate NDC number.

**State-Supplied Free Vaccines**
Prior to administering and billing state-supplied “free” vaccines, the pharmacy must have an immunization protocol approved by the Department Immunization Program. Contact the Vaccines for Children Coordinator at (208) 334-4949 for further information. Pharmacies should bill on a CMS-1500 claim form (formerly known as HCFA-1500) using the pharmacy DME provider number.

When only a free vaccine(s) is administered, the Medicaid claim must include the following information:

The appropriate CPT code for the vaccine with modifier **SL** billed at a zero dollar amount ($0.00)

Use one of the following CPT codes:

**90707** – MMR Vaccine

**90712** – Polio Vaccine – both oral and injectable

**90716** – Varicella Vaccine

**90718** – TD Vaccine (Adult)

**90720** – DPT-Hib Vaccine

**90744** – Hepatitis B Vaccine

**90645** – Hib Vaccine

**90371** – HBIG Vaccine

Administration code **90471** with modifier **U7** (one unit only)

**Injectable Flu Vaccines**

Pharmacies may bill for the administration of the Flu vaccine when performed by authorized personnel.

When billing for the administration of the vaccine use the Administration Code 90471 in conjunction with the appropriate vaccine code from the list below:

**90655** – Influenza vaccine for children 6-35 months of age (IM).

**90656** - Influenza vaccine for individuals 3 and above (IM).

**90657** - Influenza vaccine for children 6-35 months of age (IM).

**90658** - Influenza vaccine for individuals 3 and above (IM).

Administration Code **90471**

### *3.3.1.4 Therapeutic Vitamins*

Only the following therapeutic vitamins and drug products are covered. See ***Section 3.3.4, Drugs Excluded By Medicaid,*** for information on exclusions.

- Injectable vitamin B12 (Cyanocobalamin and analogues) when billed with the appropriate diagnosis
- Vitamin K and analogues
- Legend pediatric vitamin fluoride preparations
- Legend prenatal vitamins for pregnant or lactating women
- Legend folic acid
- Oral legend drugs containing folic acid in combination with vitamin B12 and/or iron salts without additional ingredients
- Legend vitamin D and analogues

### *3.3.1.5 Covered Non-legend Items*

Covered non-legend items are limited to:

- Insulin
- Disposable insulin syringes and needles (not covered for nursing home participants)
- Oral iron salts, without additional ingredients
- Permethrin rinse or shampoo
- Federal legend medication that change to non-legend status when the Director determines that they meet appropriate criteria as outlined in IDAPA 16.03.09.811

### *3.3.1.6 Contraceptives*

Oral contraceptives and diaphragms are included as a basic service provided by Medicaid. Oral contraceptives may be supplied in quantities sufficient for one, two, or three cycles.

### *3.3.1.7 Compound Drugs*

**Paper Claims**
Attach the compound drug form found in the Forms Appendix with paper claims.

**Electronic Claims**
To designate the claim as a compound drug claim combining two or more ingredients (one of which is a covered Medicaid product) a compound indicator value of 2 is required

If one or more of the ingredients being billed is a non-covered item and the pharmacy has chosen to be paid for the covered ingredients only, use a submission clarification code equal to 8. This will post a zero payment to the non-covered ingredient(s) and process the rest of the covered ingredients to pay at the applicable allowed amount.

**Required for All Compound Claims**

- Ingredient National Drug Code (NDC) for each ingredient
- Drug Name and Strength
- Quantity of each ingredient
- A unit of measure for each individual ingredient of the compound:
  - Each (EA)
  - Grams (GM)
  - Milliliters (ML, CC)
- **Ingredient cost for each ingredient** (if no value is entered, no payment will be made)
- A dosage route of administration for the final compound product:

| Code | Description |
|---|---|
| 0 | Not Specified |
| 1 | Buccal |
| 2 | Dental |
| 3 | Inhalation |
| 4 | Injection |
| 5 | Intraperitoneal |
| 6 | Irrigation |
| 7 | Mouth/Throat |
| 8 | Mucous Membrane |
| 9 | Nasal |
| 10 | Ophthalmic |
| 11 | Oral |

| Code | Description |
|---|---|
| 12 | Other/Miscellaneous |
| 13 | Otic |
| 14 | Perfusion |
| 15 | Rectal |
| 16 | Syrup |
| 17 | Topical |
| 18 | Transdermal |
| 19 | Translingual |
| 20 | Urethral |
| 21 | Vaginal |
| 22 | Enteral |

- **A dosage form** for the final compound product (form of final compound, not the ingredients) using the following codes:

| Code | Description |
|---|---|
| Blank | Not Specified |
| 01 | Capsule |
| 02 | Ointment |
| 03 | Cream |
| 04 | Suppository |
| 05 | Powder |
| 06 | Emulsion |
| 07 | Liquid |
| 10 | Tablet |

| Code | Description |
|---|---|
| 11 | Solution |
| 12 | Suspension |
| 13 | Lotion |
| 14 | Shampoo |
| 15 | Elixir |
| 16 | Syrup |
| 17 | Lozenge |
| 18 | Enema |

See the Internet at: *www.* **medicaidpharmacy.idaho.gov** for:

current listings of all drugs requiring prior authorization

Quantity Override Request forms

#### 3.3.1.8 Long Term Care Pharmacy Consultant

Medicaid pays the long term care facility directly for pharmacy consultant services. Medicaid limits reimbursement to reasonable cost.

#### 3.3.1.9 Lost, Stolen, or Damaged Prescriptions

For consideration of coverage, call the Medicaid pharmacist at (208) 364-1829 or outside the Boise area at (866) 827-9967 with the details, Monday – Friday, 8:00 am – 5:00 pm. Lost, stolen, or damaged prescriptions may be covered) based on medical necessity. Documentation in cases of theft or fire must be provided.

### 3.3.2 Quantity Standards

Medicaid reimburses for no more than a 34-day supply of continuously required medication in a calendar month as the result of a single prescription.

Beginning July 1, 2006 Idaho Medicaid will initiate an edit that calculates a daily dosage limit for medications. The daily quantity limit set by Medicaid is based primarily on FDA approved guidelines. This new edit will stop practices of "prescription splitting" that some pharmacies have developed. This practice is considered fraudulent because the pharmacy receives duplicate dispensing fees and supersedes Idaho Medicaid quantity limits.

The new edit blocks prescription splitting by calculating a daily dosage limit. For instance, if 30 units are allowed every 30 days, then 1 unit is allowed per day. Billing 30 units as a 15 day supply will no longer result in a paid claim. If the pharmacy has a previously approved prior authorization (PA) for a quantity override, this edit will acknowledge that PA and approve the claim.

The exceptions to this guideline are listed in **Section 3.3.3**, Exceptions of Quantity Standards

#### 3.3.2.1 Quantity Override Requests

Override requests must be faxed to (208) 364-1864 for consideration prior to dispensing to ensure payment. A form for this purpose is posted at www.healthandwelfare.idaho.gov. If authorization is granted, the claim can be submitted electronically.

#### 3.3.2.2 Early Refill Requests

Medicaid will reimburse for early refill requests only in two instances:

- Dosage increase with prescriber ordered change. (When 75% of the last filled prescription has been used at the new directions).
- Continued treatment after starter dose. All subsequent fills must be a prescribed quantity or a month supply, which ever is smaller.

If an early refill DUR alert appears, do **not** fill the prescription unless these conditions exist. The early refill edit may be overridden with the following NCPDP 5.1 codes:

- Reason for Service Code: **ER** (Payer/Processor Question)
- Professional Service Code: **M0*** (Medication Review)
- Result of Services Code: **1C** (Filled, with different quantity)

***** The professional service code is M '0' (zero).

## 3.3.3 Exceptions of Quantity Standards

### *3.3.3.1 Oral Drugs*

Up to 100 doses of medication may be supplied, not to exceed 100 days supply, for:

- Cardiac glycosides
- Thyroid replacement hormones
- Prenatal vitamins
- Nitroglycerin products, oral or sublingual
- Fluoride and vitamin/fluoride combination products
- Non-legend oral iron salts

Oral contraceptives may be supplied in a quantity sufficient for one, two, or three cycles.

### *3.3.3.2 Family Prescriptions*

When all members of a household are eligible for Medicaid and the prescription is written for the family (such as Lindane or Permethrin), bill the full quantity of the order using one family member's participant ID number. Do not bill Medicaid for quantities of a prescription to be used by ineligible persons.

Medicaid will only cover the cost of the covered person for any medication that is for more than one person when the second person is not covered under Medicaid (such as Metronidazole for participant and partner).

**Pharmacies must advise the participant prior to dispensing the medication if the participant is responsible for any charges.**

## 3.3.4 Drugs Excluded by Medicaid

Idaho Medicaid does **not** cover the following:

- Most non-legend (OTC) medications: This includes legend medications changed to non-legend status and their generic equivalents, regardless of prescription status. If uncertain, call MAVIS.
- Diet supplements: All diet supplements are excluded under the pharmacy program. Diet supplements, including total parenteral nutrition (TPN), may be reimbursed through Medicaid's Durable Medical Equipment (DME) program. See the Idaho Medicaid Provider Handbook for DME providers for more information on program coverage and billing instructions.
- Anorexiants: Anorexiants and related products for weight loss are excluded from coverage. Also excluded are all salts and optical isomers of these drugs and combination products containing any of the below-listed drugs. Excluded drugs include, but are not limited to, the following:

- Amphetamine
- Benzphetamine
- Chlorphentermine
- Chlortermine
- Dexfenfluramine
- Dextroamphetamine
- Diethylpropion
- Fenfluramine
- Mazindol
- Methamphetamine
- Phendimetrazine Tartrate
- Phenmetrazine
- Phentermine

- Ovulation Stimulants: Ovulation stimulants are excluded, including, but not limited to, Clomiphene Citrate, Urofollitropin, and Menotropins.
- Cosmetic Medications: Medications for cosmetic use are excluded.
- Smoking Cessation/Nicotine Products: including Nicotine chewing gum, sprays, inhalers, transdermal patches, and related products are excluded.
- Multivitamins
- The following legend multivitamins with or without minerals are excluded:
- Oral or injectable Vitamin A
- Oral or injectable Vitamin C or Vitamin E
- Any oral or injectable B-complex vitamin alone (except Vitamin B12 and analogues) or in combination with another B-complex vitamin or any other vitamin
- Other Excluded Legend Vitamins
- Other types of legend vitamins excluded from reimbursement include, but are not limited to, the following:

**Note:**
Most generic legend pre-natal vitamins and minerals are covered for pregnant or lactating women.

- Aquasol A
- Bejectal
- Berocca C
- Berroca
- Betalin Complex
- Betalin S
- Bexibee
- Cefol
- Feosol Plus
- Fergon Plus
- Ferro Folic 500
- Folbesyn
- Iberet Folic 500
- Larobec
- Lyo B-C
- Nephrovit
- Nicobid
- Pancebrin
- Pronemia
- Pyridoxine HCl
- Solu B Forte
- Solu B-C
- Tabron
- Theragran Hematinic
- Trihemic 600
- Trinsicon
- Vicon Forte

## 3.3.5 DESI Drug Explanation

### *3.3.5.1 Overview*

Prior to enactment of the Drug Amendments of 1962, drugs could be marketed as long as a manufacturer could prove the drug was safe for its intended use. The Drug Amendments of 1962 required a manufacturer to prove drugs safe and effective. Drugs marketed prior to 1962 were allowed to remain in the market place while they were reviewed to determine evidence of effectiveness.

The program established to review the effectiveness of drugs approved prior to 1962 was named the Drug Efficacy Study Implementation (DESI) program. The DESI program's purpose is to foster use of drugs whose efficacy is not in question.

Since the early 1980s, the Federal government has prohibited the use of federal funds to purchase drugs identified by the DESI program and determined by the Food and Drug Administration (FDA) to lack substantial evidence of effectiveness for all labeled indications. This policy also applies to identical, similar, and related drugs.

### *3.3.5.2 Identical, Similar, or Related Drugs*

A drug which has an equivalent formulation to the DESI listing or where one or more active ingredients are added to a DESI product that has been classified as lacking substantial evidence of effectiveness, the resultant drug product will also be considered lacking substantial evidence of effectiveness and not reimbursable.

### *3.3.5.3 DESI Listing*

For a complete listing of DESI drugs excluded from payment by Medicaid, see the Medicaid Pharmacy Website. The list shows the brand name of the drug, dosage information, and active ingredients. Drugs containing the same active ingredients are grouped together. Equivalents not listed are also excluded.

DESI determinations are specific to the route of administration unless there is something unique about the dosage form reviewed. For a complete listing of excluded DESI drugs, see the Internet at **www.medicaidpharmacy.idaho.gov**.

# 3.4 Prior Authorization (PA)

## 3.4.1 Overview

Prescribers **must** request prior authorization (PA) for the following drugs:

- Brand name drugs when an acceptable generic form is available
- Other medications as determined by Medicaid for therapeutic and/or pricing issues

See the Internet at: **www.medicaidpharmacy.idaho.gov** with links to the pharmacy program for current listings of all drugs requiring prior authorization and for forms.

If the claim denies for PA and the prescriber wants to pursue obtaining a PA, the prescriber will need to contact the Medicaid Pharmacy Call Center at (208) 364-1829, or outside the Boise area at (866) 827-9967, fax or mail in a completed PA form. PA forms can be located on the Medicaid Pharmacy website: **www.medicaidpharmacy.idaho.gov** or from:

Idaho Medicaid
Bureau of Medical Care
**Pharmacy Program**
P.O. Box 83720
Boise, ID 83720-0036
FAX: (208) 364-1864

**Note:** EDS is not an authorizing agency for any Medicaid services and does not issue prior authorizations.

When calling the Medicaid Pharmacy Call Center, the prescriber will need to give the Call Center staff the following information:

- Participant's name, MID number, and date of birth
- Participant's diagnosis
- Drug strength and dosage
- Statement of medical necessity
- Anticipated duration of therapy, not to exceed twelve (12) months
- Name and fax number of provider pharmacy
- Participants must have failed or be intolerant of a minimum of two equivalent generic medications, documented on a FDA MedWatch form, for consideration of brand name approval

Pharmacy Call Center staff inputs the needed information into the SmartPA application. SmartPA then automatically queries both the medical and pharmacy databases and input information to determine if the PA criteria have been met.

Approval or denial is faxed to the prescribing physician's office and selected pharmacy.

Requests for retroactive PAs will be considered only when retroactive eligibility is involved.

## 3.4.2 72-Hour Emergency Supplies

Medicaid will pay for point-of-sale (POS) pharmacy claims for a 72-hour emergency supply of medications requiring PA if the pharmacist in his/her professional judgment believes a participant has an immediate need. The

appropriate PA process must be utilized during regular business hours. All of the following conditions must be met for an emergency supply:

- The participant is Medicaid eligible on the date of service
- The prescription is new to the pharmacy
- The medication requires PA
- The days supply for the emergency period does not exceed three (3) days

The override codes for billing for a 72-Hour emergency supply are:

- Reason for Service Code: **TP** (Payer/Processor Question)
- Professional Service Code: **MR** (Medication Review)
- Result of Services Code: **1F** (Filled, with different quantity)

**Note:** as of May 5, 2003:

- DUR conflict codes are called reason for service codes.
- DUR intervention codes are called professional service codes.
- DUR outcome codes are called result of service codes.

A completed PA request must be faxed to the Medicaid Pharmacy at (208) 364-1864.

### 3.4.3 Pharmacy Forms

The medication specific PA form, the quantity override request form, and a generic PA form are available on the Internet at the Idaho Medicaid Website: **www.Medicaidpharmacy.idaho.gov**.

The Compound Drug Information Form is available in the *Forms Appendix* of this handbook.

# 3.5 Medical Supply Items

## 3.5.1 Durable Medical Equipment (DME)

Payment for items that are considered by Medicaid to be medical supplies and not drugs can only be made to approved DME providers. A pharmacy may apply for and become an approved DME provider. In this situation the pharmacy will have more than one provider number and must follow the billing regulations for each claim type. For billing instructions for supplies, see the Idaho Medicaid Provider Handbook for DME providers. DME items must be billed using national HCPCS codes on the CMS 1500 claim form.

Idaho Medicaid follows coverage criteria and quantity limitations as stated in the DMERC supplier manual. Exceptions and additional information are listed in IDAPA 16.03.09.106, *Rules Governing the Medical Assistance Program.*

A separate provider handbook for DME providers is available on the Idaho Medicaid Provider CD to assist in billing for medical supplies. Please see ***Section 1.2, Provider Agreement***, for more information on provider enrollment.

If a participant is a Healthy Connections participant, a referral is required from the primary care physician.

## 3.5.2 General Guidelines

To determine if a code requires PA, call MAVIS at:

(800) 685-3757
(208) 383-4310

Check with MAVIS to determine if a certain procedure code requires PA. Inquiries should be directed to Medicaid Bureau of Medical Care , DME Program, toll free (866) 205-7403. PA requests may be submitted by FAX to (800) 352-6044 with medical necessity documentation attached.

## 3.5.3 Diabetic Supplies

Diabetic test strips, lancets, needles, insulin syringes, alcohol wipes, and blood glucose monitors can be billed electronically or on a CMS-1500 claim form using HCPCS procedure codes and the provider's DME provider number.

## 3.5.4 Long Term Care Facility Limitations

Intravenous supplies, insulin syringes, needles, diabetic test strips, and other medical supply items are considered part of the routine supply items for long term care facility participants. Payment for these items is made directly to the long term care facility as part of the per diem rate. Pharmacies that provide these supplies to long term care facility patients must bill the facility directly.

# 3.6 Payment

## 3.6.1 Basis of Payment

Payment to pharmacies is limited to the lowest of the following:

- Federal established upper limit (FUL) of payment for multi-source drugs plus the assigned dispensing fee.
- State established maximum allowable cost (SMAC) plus the assigned dispensing fee.
- Discounted Average Wholesale Price (DISC AWP) supplied by First Data Bank (FDB) plus the assigned dispensing fee.
- The pharmacy's usual and customary charge (see Section 3.6.4, Usual and Customary Charges, for a definition).
- Products from labelers not participating in the National Medicaid Drug Rebate Program are not covered by Idaho Medicaid. No waiver procedure is available for non-participating drug manufacturers' products.

## 3.6.2 Upper Payment Limit

### *3.6.2.1 Multi-Source Upper Limit Drugs*

Many multi-source drugs are reimbursed based upon the upper payment level known as FUL (Federal Upper Limit) or SMAC (State Maximum Allowable Cost) plus a dispensing fee. FUL is established by The Centers for Medicare and Medicaid services (CMS). SMAC is set by the Idaho Division of Medicaid through a contractor. See the Medicaid Pharmacy Website for a complete listing of the multi-source drugs covered by Medicaid, see the Medicaid Pharmacy Website.

## 3.6.3 Discounted Average Wholesale Price (DISC AWP)

DISC AWP is based on discounting the average wholesale price determined by First DataBank by 12%. The drug pricing subsystem is updated weekly.

## 3.6.4 Usual and Customary Charges

The usual and customary charge is defined as: charges for the same services and items when provided to persons not entitled to receive benefits under the Idaho Medicaid Program.

Regardless of the formula utilized by Medicaid to calculate the maximum reimbursement amount, no pharmacy may bill Medicaid more than the usual and customary charge that is billed to the general public for the same medication, including advertised specials.

## 3.6.5 National Medicaid Drug Rebate Program

To obtain federal Medicaid funding, payment may only be made for products whose manufacturers/labelers provide specified rebates to the state Medicaid program. A list of the participating manufacturers is available at the Medicaid Pharmacy Website.

Because of the rebate program, it is essential that correct NDCs, units, and unit of measure be billed to Medicaid. Claims submitted with incorrect NDC numbers, units, or unit of measure will be denied or recouped.

Complete FUL and SMAC lists are available on the Internet at:

**www.medicaidpharmacy.idaho.gov**.

Complete FUL lists are also available at:

**www.cms.hhs.gov/medicaid/drugs/drug10.asp**.

## 3.6.6 Dispensing Fees

Dispensing fees are defined as the cost of filling a prescription including direct pharmacy overhead. The Division of Medicaid periodically conducts dispensing cost surveys that may be used as the basis of assigning dispensing fees.

Medicaid utilizes a dispensing fee for unit-dose providers that is different from the regular-dose dispensing fee for all other pharmacy providers. Only one dispensing fee per calendar month will be allowed for the dispensing of each maintenance drug to any participant as an outpatient or in a long term care facility except as listed in **Section 3.6.6.1, *Exceptions***.

**Note:**
See **Section 3.1.3.3** for more information on unit-dose providers.

### *3.6.6.1 Exceptions*

Exceptions for the multiple dispensing of a maintenance drug include:

- Multiple dispensing of topical or injectable medications when dispensed in the manufacturer's original package size except when evidence exists, as determined by Medicaid, that the quantity dispensed does not relate to the prescriber's order.
- Multiple dispensing of oral liquid maintenance medication if a reasonable quantity, as determined by Medicaid, is dispensed at each filling.
- When the dose is being titrated for maximum therapeutic response with a minimum of adverse effects.

# 3.7 Claims Submission

## 3.7.1 Claim Forms

Submit claims for legend (prescription) and approved non-legend (over-the-counter) drugs electronically by modem, point of service (POS), or interactively using software from EDS (PES) or other vendor software using the NCPDP 5.1 format.

Claims may also be billed on Pusing the unique State of Idaho drug claim form. Claim forms are supplied at no charge to the provider. A sample Pharmacy Claim form appears in Section **3.7.3.5, Sample Paper Pharmacy Claim Form**.

All medical supplies are billed on a CMS (formerly HCFA) 1500 claim form or electronically using the 837 professional form and must be billed using a Durable Medical Equipment (DME) Idaho Medicaid provider number.

All claims must be received within one year of the date of service.

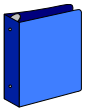
To order pharmacy paper claim forms and for additional information regarding claim forms, contact EDS at:

383-4310 from the Boise calling area, or

(800) 685-3757 outside the Boise calling area

Monday through Friday (except holidays) from 8 a.m. - 6 p.m. MT

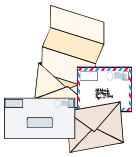
**For more information**



See **Section 2.2.2** for electronic billing.

See **Section 3.5** in the *Idaho Medicaid Provider Handbook for Durable Medical Equipment (DME)* for instructions on how to bill supplies.

## 3.7.2 Where to Mail the Paper Form



Send to:

**EDS**
P.O. Box 23
Boise, ID 83707

## 3.7.3 How to Fill Out the Paper Pharmacy Claim Form

### *3.7.3.1 Overview*

The following will speed claim processing:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly with data in the correct field to facilitate electronic scanning.
- Keep claim form clean. Use correction tape to cover errors.
- A maximum of 10 line items per claim can be accepted.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed.

### *3.7.3.2 Completing Specific Fields*

Refer to **Section *3.7.3.5, Sample Paper Pharmacy Claim Form*,** for a sample claim with all fields numbered. Provider questions regarding

pharmacy policy and coverage requirements are referred to the *Rules Governing the Medical Assistance Program* manual.

EDS denies incomplete claims. Every effort should be made to provide valid, complete information as specified on the claim form. The following numbered items correspond to the unique drug claim form.

### 3.7.3.3 Quantity Billing

Medicaid accepts unit quantities (including decimal fractions) and unit descriptions to match what drug labelers have reported to the Center for Medicare and Medicaid Services (CMS) for the National Medicaid Drug Rebate program.

Providers must comply with the standard reporting format requested by the rebate program. Check MAVIS if uncertain about reporting quantity.

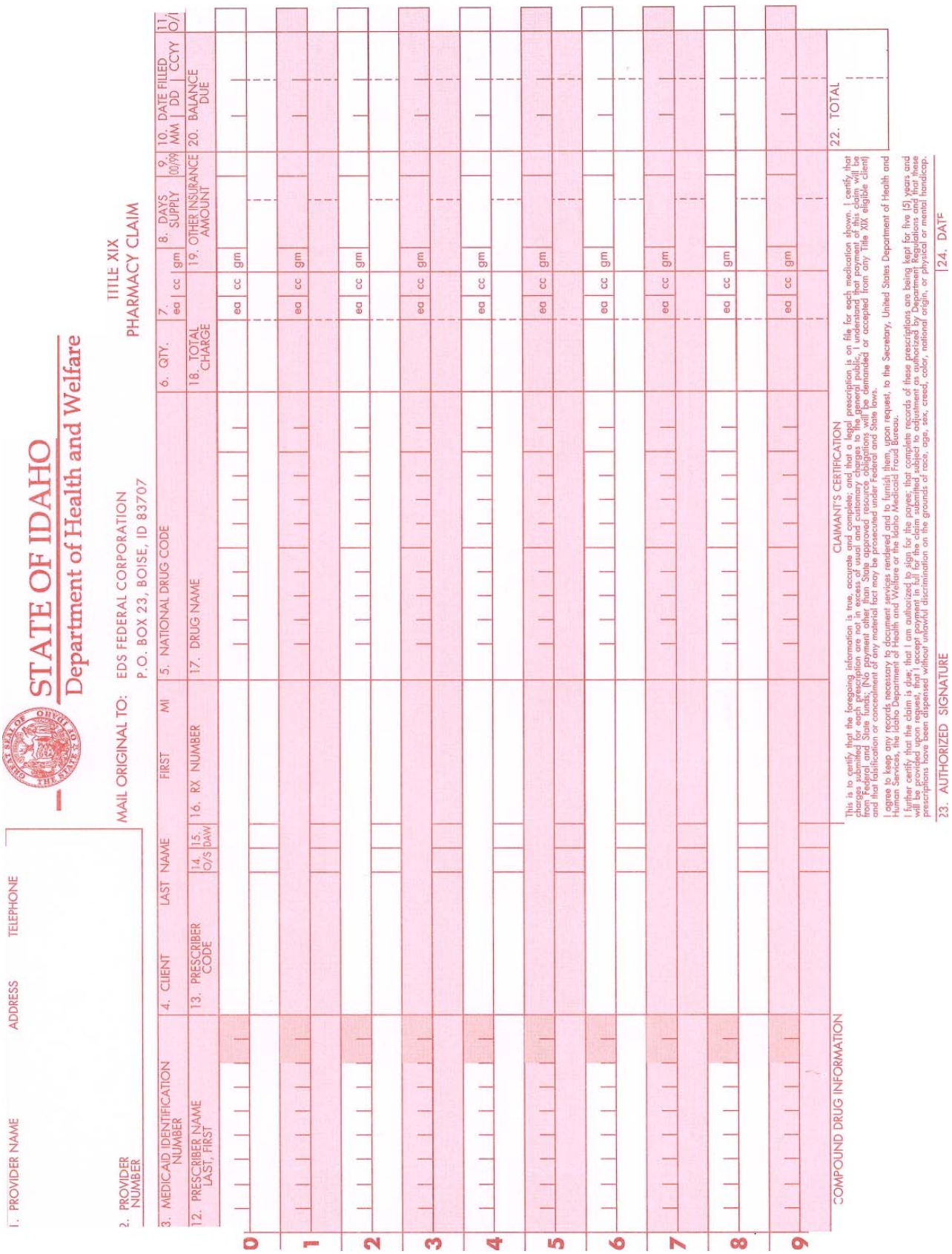
For pharmacy computer systems that do not permit exact decimal quantity amount entries on the claim, list exact quantity amounts in field 6 of a paper claim. Reporting the exact quantity amounts allows Medicaid to provide accurate rebate information to the drug labelers.

### 3.7.3.4 Paper Pharmacy Claim Form Fields

| Field | Field Name | Use | Description |
|---|---|---|---|
| **1** | Provider Name, Address, and Phone Number | Required | Providers enter the pharmacy name exactly as it appears on the RA. **Note:** If there has been a change of name, address or ownership, please, immediately notify EDS Provider Enrollment, in writing, so they can update the Provider Master File. Change in ownership requires a new provider application. |
| **2** | Provider Number | Required | Providers enter their assigned provider number. |
| **3** | Participant's Medicaid ID Number | Required | Enter the participant's seven-digit Medicaid ID (MID) number as indicated on the plastic ID card. |
| **4** | Participant's Name | Required | Enter the participant's last name, first name and middle initial, exactly as the name appears on the plastic ID card. |
| **5** | National Drug Code | Required | Enter the 11-digit National Drug Code (NDC). The NDCs are arranged in the 5-4-2 digit configuration. The first five digits identify the manufacturer, the middle four digits identify the product, and the last two digits identify the package size. Let zeros fill in appropriate areas to conform to the 5-4-2 configuration.<br>**Example:** 978-483-10 should be indicated as 00978-0483-10. The NDC submitted on the claim form must accurately represent the NDC on the container of drug product from which the prescription was dispensed. Use 00000-0000-00 for compound prescriptions. List the NDCs of the ingredients and the quantity in the compound on an attached Compound Information Form which can hold up to 10 compounds. |
| **6** | Quantity | Required | Enter the metric quantity of the dispensed drug. The exact quantity must be reported for each drug dispensed. The CMS reportable units and quantities may be confusing. If uncertain, call MAVIS. |
| **7** | Measurement | Required | Enter the metric measurement of the dispensed drug. Each (ea.) grams (gm) mililiter (cc, ml) . If unsure of the appropriate unit of measure, call MAVIS. |

| Field | Field Name | Use | Description |
|---|---|---|---|
| **8** | Days Supply | Required | Enter the number of days that the prescription should last. An estimated day's supply must be indicated if the "sig" is "prn" or "not applicable." Do **not** leave this field blank. |
| **9** | New Refill<br>00/99 | Required | Indicate the number of times the prescription has been filled. **Example:** the original fill is indicated as 00, the first refill is 01, the second refill is 02, etc. |
| **10** | Date Filled | Required | Always use the complete date in MM/DD/CCYY (month, day, century, and year) format *Example*: April 1, 2010 would be entered as 04/01/2010. |
| **11** | Other Insurance | Required | Mark **Y** for yes and **N** for no if there is any additional drug coverage for the participant. |
| **12** | Prescriber Name | Required | Enter the complete name of the prescriber. |
| **13** | Prescriber Code | Required | Enter the prescriber's state professional license number.<br>See Section 3.1.5, Prescriber License Number, for more information.<br>**Note:** In order for the scanning process to differentiate between an Alpha O or a numeric zero, please put a slash mark through all zeroes. |
| **14** | Out-of-State (O/S) | Required if applicable | Check this box if the prescriber is not licensed within the State of Idaho. |
| **16** | RX Number | Required | Enter the prescription number. |
| **17** | Drug Name | Required | Enter the drug name and strength. If the prescription is compounded, enter the word compound |
| **18** | Total Charge | Required | Enter your usual and customary charge. |
| **19** | Other Insurance Amount | Required | Enter any amount paid by other liable parties or health insurance payments including Medicare. Attach documentation from an insurance company showing payment or denial to the claim. See Section 2, for more information on third party resources (TPR). |
| **20** | Balance Due | Required | Enter the difference between fields 18 and 19 |
| **21** | Compound Drug Information | Required if billing a compound (on paper only) | If any of the prescriptions were compounded, use NDC code of 00000-0000-00 in field 5 and attach Compound Form as instructed in section 3.3.1.7 of the Pharmacy Provider Handbook.<br>Presumptive Eligibility (PE): use this field for the participant's name, social security number, and birth date when applicable.<br>Hospice Information as required. See section 3.2.5 of the Pharmacy Provider Handbook.<br>Prescribing Provider Number: use this field when more than 7 characters in length and put a slash through all zeroes. |
| **22** | Total | Optional | Enter the sum of all charges. |
| **23** | Authorized Signature | Required | The authorized agent or pharmacist must sign the claimant's certification. Providers may use *'Signature on file'* if a form has been filed with EDS. See **Section 1.2** for more information. |
| **24** | Date | Required | Enter the date the claim form was signed. |

### 3.7.3.5 Sample Paper Pharmacy Claim Form



### 3.7.3.6 Compound Detail NDC Attachment Form

When submitting claims for compound drugs, use the Compound Detail NDC Attachment form along with the paper Pharmacy Claim form shown in Section 3.7.3.5. For a copy of the Compound Detail NDC Attachment Form, refer to the Forms section of this handbook.